

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Dr. S, D.C. PO Box 292762 Lewisville, Texas 75029	MDR Tracking No.: M4-03-7445-01
	TWCC No.: _____
	Injured Employee's Name: _____
Respondent's Name and Address Fort Worth ISD Box 01	Date of Injury: _____
	Employer's Name: _____
	Insurance Carrier's No.: 82691356065862

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/05/02	06/05/02	97139-AC	\$56.00	\$0.00
08/21/02	08/21/02	97139-AC	\$56.00	\$0.00
08/28/02	08/28/02	97139-AC	\$56.00	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "The additional information consists of the TWCC-14-Day request letter, a copy of the Request for Reconsideration, Patient Profiles, Patient Referrals, Copies of soap notes for all DOS and any additional EOB's received (If any) for all DOS."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "ESIS, as Servicing Contractor for FWISD, Self-Insured, advises that said bills have been submitted and paid according to the ascribed guidelines and no additional charges are due." Carrier's EOBs denied services as, "M-Reduced to fair and reasonable. F-Reduction according to Medical Fee Guidelines."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per Commission Rule 133.307(j)(f), the reimbursement for this CPT code would be at a "fair and reasonable" rate.
The requestor did not submit product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicates that their charges were fair and reasonable per rule 133.307(g)(3)(D).
Therefore, based on this information additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

[illegible]

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

Michael Bucklin

12/27/04

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____